STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445310	A. BUILDING _____ B. WING _____	08/22/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF COPPER BASIN	166 COPPER BASIN INDUSTRIAL PARK PO BOX 518 DUCKTOWN, TN 37326

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS During annual suvey recertification survey and complaint investigation #29891, conducted on August 20-22, 2012, at Life Care Center of Copper Basin. No deficiencies were cited in relation to the complaint under 42 CFR PART 482.13, Requirements for Long Term Care Facilities.	F 000	**Life Care Center of Copper Basin** Preparation of and/or execution of this plan of correction does not constitute admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and execute solely because of federal and state requirements.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain dignity during the noon meal for five residents in the dining room and failed to provide dignity for one resident (# 66) by not covering a catheter. The findings included: Observation on August 20, 2012, at 12:04 p.m. of the noon meal revealed six residents seated at one table and only one resident had a meal tray and was eating from this tray. Continued observation revealed one of the six residents was asleep with the resident's head resting on the end of the table. Further observation revealed the five other residents at the table did not receive a tray until 12:26 p.m., (twenty two minutes) after resident # 89 had received a tray and had completed the meal.	F 241	**1. CORRECTIVE ACTION – F 241** A. The nurse assigned to the dining room for the noon meal was educated regarding dignity of residents during dining on 8/20/12 by the Director of Nursing (DON). B. A privacy bag was placed over the catheter bag of resident #66 on 8/20/12 by a Certified Nursing Assistant (C.N.A.). Other residents with indwelling catheters were checked for privacy covers by the DON on 8/20/12 and they were in place. **2. OTHER RESIDENTS WHO COULD POTENTIALLY BE AFFECTED** Residents that are served meals in the dining areas have the potential to be affected. Residents with indwelling catheters have the potential to be affected **3. WHAT MEASURES WERE PUT IN PLACE** Nursing staff were educated regarding dignity of residents during dining on 8/20/12 by the DON. Nursing staff were educated on the placement of privacy covers for all residents with indwelling catheters on 8/20/12 by the DON of Assistant Director of Nursing (ADON). Observation of residents with	9/14/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 9/5/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	Continued From page 1 Interview in the North Wing Dining Room, with Minimum Data Set (MDS) Coordinator #1 on August 20, 2012, at 12:30 p.m., confirmed the facility failed to ensure all residents seated at the same dining table received meal trays at the same time. Resident #66 was admitted to the facility on June 4, 2009, with Neurogenic Bladder, Dementia with Behavioral Distrubances, and Hypertension. Observation with Licensed Practical Nurse (LPN) # 1 on August 21, 2012, at 1:45 p.m., revealed the resident lying in bed. Further observation revealed the resident had an indwelling catheter which was connected to a exposed drainage bag hanging on the bottom rail of the resident's bed. Interview at that time with LPN #1 confirmed the resident's catheter drainage bag is to be covered at all times to preserve the resident's dignity.	F 241	indwelling catheters to ensure privacy covers are in place will be completed 2 times per week for a period of 4 weeks and then weekly for 8 weeks by the DON or ADON. 4. **MONITORING** Dining observation and catheter privacy bag observation will be taken to Performance Improvement Committee by the DON and reviewed monthly to ensure resident's dignity is maintained. The PI Committee will review and if deemed necessary by the committee, additional education may be provided; the process evaluated/revised and/or logs reviewed for 3 months or until 100% compliance is achieved. **Life Care Center of Copper Basin** Preparation of and/or execution of this plan of correction does not constitute admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and execute solely because of federal and state requirements.	
F 252 SS=D	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide a homelike environment in the North Wing Dining Room.	F 252	1. **CORRECTIVE ACTION – F 252** The nurse assigned to the dining room for the noon meal was educated by the Director of Nursing (DON) regarding honoring resident preferences for seating and meal placement. 2. **OTHER RESIDENTS WHO COULD POTENTIALLY BE AFFECTED** Residents that are served meals in the dining areas have the potential to be affected.	9/14/12

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F 252	Continued From page 2 The findings included: Observation in the North Wing Dining Room on August 20, 2012, at 12:29 p.m., revealed six residents seated in wheelchairs eating from tray carts without the food removed from the trays. Interview in the North Wing Dining Room, with Minimum Data Set (MDS) Coordinator #1 on August 20, 2012, at 12:30 p.m., confirmed the facility failed to provide a homelike environment by not seating residents in dining room chairs and not removing plates from tray carts.	F 252	**3. WHAT MEASURES WERE PUT IN PLACE** Nursing staff were educated regarding resident preference for seating and meal placement during dining on 8/20/12 by the DON. Observation of the dining area will be completed for one meal daily for a period of 5 days for one week, then 3 days for 3 weeks, then once a week for 8 weeks, by the DON or ADON **4. MONITORING** Dining observation log will be taken to Performance Improvement Committee by the DON and reviewed monthly to ensure resident's dignity is maintained. The PI Committee will review and if deemed necessary by the committee, additional education may be provided; the process evaluated/revised and/or logs reviewed for 3 months or until 100% compliance is achieved. **Life Care Center of Copper Basin** Preparation of and/or execution of this plan of correction does not constitute admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and execute solely because of federal and state requirements.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279	**1. CORRECTIVE ACTION – F 279** Resident #7 was a discharged resident, unable to revise the closed record for care plan regarding an indwelling catheter. **2. OTHER RESIDENTS WHO COULD POTENTIALLY BE AFFECTED** Residents that have indwelling catheters have the potential to be affected.	9/14/12

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F 279	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to update a care plan for one resident (#7) of thirty one residents reviewed in stage two. The findings included: Resident #7 was readmitted to the facility on March 1, 2012, with diagnoses including Atrial Fibrillation, Osteoporosis, Alzheimer's Disease, Muscle Weakness, Urinary Retention, and Hypertension. Review of the hospital discharge summary dated March 1, 2012, revealed indwelling urinary catheter placed due to urinary retention. Review of the updated care plan dated March 8, 2012, revealed the care plan did not address the indwelling urinary catheter. Interview with the Director of Nursing (DON) on August 22, 2012, at 9:15 a.m., in the DON's office, confirmed the care plan did not address the issue of the resident's indwelling urinary catheter.	F 279	3. **WHAT MEASURES WERE PUT IN PLACE** A 100% care plan audit of all residents with indwelling catheters was completed on 8/27/12 by the Regional Director of Clinical Services. The Minimum Data Set Coordinators were educated regarding indwelling catheter care plans on 8/27/12 by the DON. A Care Plan audit of all residents with indwelling catheters will be completed by the DON or ADON for a period of 2 times a week for 4 weeks then weekly for 8 weeks. 4. **MONITORING** Care plan audit results will be taken to Performance Improvement Committee by the DON and reviewed monthly. The PI Committee will review and if deemed necessary by the committee, additional education may be provided; the process evaluated/revised and/or logs reviewed for 3 months or until 100% compliance is achieved.	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to	F 428	**Life Care Center of Copper Basin** Preparation of and/or execution of this plan of correction does not constitute admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and execute solely because of federal and state requirements. 1. **CORRECTIVE ACTION – F 428** There were no pharmacy recommendations for August 2012.	9/14/12

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F 428	Continued From page 4 the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to respond timely to pharmacy recommendations for gradual dose reduction and discontinuation of medications prescribed for one resident (#110) of ten review reviewed. The findings included: Resident #110 was admitted to the facility December 7, 2011, with diagnoses including Other Rehab, Coronary Artery Disease, Congestive Heart Failure, Right Heart Failure, Osteoarthritis, Diabetes Mellitus, Depression, Agitated States and Aggressive Behaviors. Medical record review of the Quarterly Pharmacy Consultation Report and Recommendation dated April 18, 2012, revealed "Comment:...(Resident) has received geodon (an antipsychotic)20 mg BID (twice daily) since 12/7/11. Recommendation: Please consider a gradual dose reduction of geodon 20mg. Response Requested ...Physician Response:...(box checked) I accept the recommendation(s) above, please implement as written." Continued medical record review revealed the physician's signature with no date entered after the signature and a hand written entry below "noted 4/27/12...(initialed by a nurse)."	F 428	2. **OTHER RESIDENTS WHO COULD POTENTIALLY BE AFFECTED** Residents that are addressed on the pharmacy consultant report have the potential to be affected. 3. **WHAT MEASURES WERE PUT IN PLACE** The Director of Nursing (DON) was educated regarding the pharmacy recommendation tracking log on 8/27/12 by the Regional Director of Clinical Services. Pharmacy recommendations tracking log will be monitored by the Director of Nursing to ensure response times and physician dating of recommendations. The attending physicians will be educated on 9/7/12 regarding response time and dating of pharmacy recommendations by the DON. 4. **MONITORING** Pharmacy tracking logs will be taken to Performance Improvement Committee by the DON and reviewed monthly. The PI Committee will review and if deemed necessary by the committee, additional education may be provided; the process evaluated/revised and/or logs reviewed for 3 months or until 100% compliance is achieved.	

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F 428	Continued From page 5 Medical record review of a Physician's telephone Order dated April 27, 2012, revealed "...4/27/12 DC (discontinue) geodon 20 mg BID start Geodon 10 mg BID..." Further medical record review of the Quarterly Pharmacy Consultation Report and Recommendation dated July 18, 2012, revealed "Comment; ...receives a tertiary, tricylic antidepressant (TCA), Amitriptyline HCL 10 mg HS (at bedtime). Recommendation: "Please reevaluate continued Amitriptyline HCL use and consider discontinuation or alternative therapy. Physician Response: ...(box checked) I accept the recommendation(s) above, please implement as written." Continued medical record review revealed the physician's signature with no date entered after the signature and a hand written entry "noted August 7, 2012...(initialed by a nurse). Interview with the Director of Nursing (DON) on August 21, 2012, at 3:30 p.m., in the DON's office, confirmed the physician's signatures with no dates and the nurses' initialed responses which resulted in a nine day delay and a twenty day delay in implementation of the pharmacist's recommendations for the resident.	F 428		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441	**Life Care Center of Copper Basin** Preparation of and/or execution of this plan of correction does not constitute admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and execute solely because of federal and state requirements. 1. **CORRECTIVE ACTION – F 441** The nurse was educated on 8/20/12 by the Director of Nursing (DON) that if any resident spits on any surface it is to be disinfected promptly	9/14/12

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F 441	Continued From page 6 (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to maintain infection control in the North Wing Dining Room. The findings included:	F 441	2. **OTHER RESIDENTS WHO COULD POTENTIALLY BE AFFECTED** Residents that reside in the facility have the potential to be affected. 3. **WHAT MEASURES WERE PUT IN PLACE** Facility staff were educated by the DON on 8/20/12 regarding disinfecting surfaces if residents are observed spitting. Observation of the dining area to ensure any spit areas are disinfected will be completed for one meal daily for a period of 5 days for one week, then 3 days for 3 weeks, then once a week for 8 weeks by the DON or Assistant Director of Nursing (ADON). 4. **MONITORING** Dining room observation log will be taken to Performance Improvement Committee by the DON and reviewed monthly. The PI Committee will review and if deemed necessary by the committee, additional education may be provided; the process evaluated/revised and/or logs reviewed for 3 months or until 100% compliance is achieved.	

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F 441	Continued From page 7 Observation in the North Wing Dining Room on August 20, 2012, at 12:04 p.m., revealed resident #170 self propelling in a wheelchair. Continued observation revealed the resident spat on the wall. Observation revealed the resident then self propelled over to resident #84 and spat on the hand brake control of resident #84's wheelchair. Continued observation revealed the Minimum Data Set (MDS) coordinator #1 redirected resident #170 but failed to clean or notify anyone of the spit on the wall and wheelchair. Interview with the MDS coordinator #1 in the North Wing Dining Room on August 20, 2012, at 12:32 p.m., confirmed the wall and wheelchair were not disinfected.	F 441		

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